STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155712	A. BUILDING 00 B. WING	08/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVERED BRIDGE HEALTH CAMPUS	1675 W TIPTON ST SEYMOUR, IN 47274

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00114805. Survey dates: August 13, 14, 15, 16, 17, 20 and 21, 2012 Facility number: 003342 Provider number: 155712 AIM number: 200403740 Survey team: Marla Potts, RN TC (August 13, 14, 15, 16 and 17, 2012) Sharon Whiteman, RN Susan Worsham, RN Carol Dierks, RN (August 13, 14, 15, 16 and 17, 2012) Kim Perigo RN (August 13, 14, 15, 16 and 17, 2012) Census Bed Type: SNF: 15 SNF/NF: 40 Residential: 35 Total: 90 Census Payor Type: Medicare: 16 Medicaid: 23	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Other: 51 Total: 90 Residential Sample: 8 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 8/28/12 by Suzanne Williams, RN			

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F0170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. Based on interview and record review, the facility failed to ensure mail was delivered to residents Saturdays. This had the potential to affect all residents who would receive mail on Saturdays. Findings include: During an interview with the Resident Council President on 8/15/12 at 2:30 p.m., the president indicated residents do not receive mail on Saturdays. During an interview with the Activities Director on 8/15/12 at approximately 3:30 p.m., the Activities Director indicated the activities department staff deliver the mail to residents after it is sorted by the business office. She indicated the business office does not usually sort the mail on the weekends, so it is not delivered on Saturdays. During an interview with the Business Officer Manager on 8/15/12 at approximately 3:45 p.m., the	F0170	F 0170 CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE:Activity Director will meet with Resident council and inform them of change in delivery of mail that will include Saturday delivery to residents by Activity staff beginning August 18th, 2012. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN: All residents have the potential to be affected by this alleged deficient practice. All residents began receiving mail on Saturday, August 18th.MEASURES PUT IN PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Activity staff or designee delievering mail on Saturday will take census sheet/roster and hi-light names of residents that received mail on that day to designate proof of delivery. HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO	09/20/2012

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	Business Office Manager indicated she sorts the mail and it is delivered Monday through Friday by the activities department staff. She indicated there is not Saturday delivery of mail. On 8/16/12 at 10:38 a.m., a facility policy presented by the Executive Director regarding mail delivery indicated, "...Promptly means delivery of mail or other materials to the resident within 24 hours of delivery by the postal service...." At this time, the Executive Director indicated the residents have not been receiving mail on Saturdays. 3.1-3(s)(1)		ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR: ED or designee will conduct audit weekly of census sheet/rosters and these will also be presented by Activity Director to Quality Assurance Committee monthly for further recommendations. WHAT SYSTEMIC CHANGES TO ENSURE DEFICIENT PRACTICE DOESN'T RECUR? I.E. POLICY AND PROCEDURE REVIEW OR IMPLEMENTATION? INSERVICES? HOW LONG WILL QA MONITOR THE MEASURES? WHAT CRITERIA WILL USE TO DETERMINE MONITORING CAN BE DISCONTINUED?ADDENDUM: Resident Activity Director met with her staff on 8-17-12 to inform them of the need to deliver mail to residents on Saturday every week. She is having another inservice with her staff on 9-26-12 on the Saturday delivery, and the Activity staff must attend a mandatory inservice on 9-25 or 9-27-12 also. The Activity staff implemented this change on 8-18-12. All department heads that are part of our WeekStart Manager program are also aware of the change and can monitor compliance with their WeekStart Manager forms. The audits conducted by the ED or designee weekly for 6 months will be taken to the QA committee for further recommendations. If there have been no issues at the end of 6	

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			months with resident mail being passed, then monitoring will be discontinued at that time.	

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F0224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure a resident was free from mistreatment, in that a nursing staff member argued with and upset 1 of 3 residents reviewed for abuse. (Resident #80) Findings Include: Interview of Rehab Technician #1 on 08/14/12 at 11:20 a.m. indicated she was aware of an incident a few months ago which involved a CNA arguing with a resident (Resident #80) and causing the resident to be upset and tearful. The Rehab Technician indicated the CNA still worked at the facility. The Rehab Technician indicated she immediately reported the incident to her supervisor. Interview of Rehab Technician #1 on 08/14/12 at 1:21 p.m. indicated the incident was brought to her attention when she (Rehab Technician #1) went to get Resident #80 to take her for therapy. The Rehab Technician	F0224	F 0224 CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: Resident #80 received a follow up visit after successfully completing therapy on Health Center and moving to Assisted Living, and expresses no negative outcome from the incident involving the CNA mentioned in the survey. She is very happy with her care at the campus and has even recommended the facility to her sister who is also now a resident on AL. The CNA has since been terminated following a reportable incident which took place during the residential portion of our annual survey. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTION TAKEN: All residents have the potential to be affected by alleged deficient practice.MEASURES PUT INTO PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT	09/20/2012

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	#1 indicated the CNA (CNA #9) had argued with Resident #80 about getting out of bed for breakfast. The Rehab Technician indicated, "[CNA#9] started arguing with the resident [Resident #80] in front of me about getting out of bed. It wasn't a loud yell - just an uncomfortable banter between the resident & [CNA #9]. I remember the CNA just left and I took [name of resident] to therapy. I had to take time to settle [name of resident] down because she was crying. [Name of resident] begged me not to report it. I (Rehab Technician #1) reported to my boss immediately & she told me to report it to [name of Social Services Director]. I did a verbal report & [name of the Social Services Director] followed up with [name of the resident]." The Rehab Technician indicated a week or two later, the DON stopped her in the hallway and asked her about the incident. Interview of the Executive Director on 08/15/12 at 11:50 a.m. indicated she was not involved in the investigation of the incident between CNA #9 and Resident #80. The Executive Director indicated the DHS [Director of Health Services] did the investigation and she (the Executive Director) signed off on it. The Executive Director		PRACTICE DOES NOT RECUR:Support Clinical Nurse will review Campus Guidelines for Abuse Investigation and Reporting with Leadership Team including ED, DHS, ADHS, Social Service. ED or designee will review same information with staff.HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:ED or designee will conduct resident and staff interviews regarding abuse and neglect, investigating and reporting specifically related to verbal abuse. 3 resident and 3 staff interviews will be completed weekly X 60 days and then weekly X 4 months. The interviews will be presented to the Quality Assurance Committee for further recommendations. WHAT CRITERIA WILL QA USE TO DETERMINE MONITORING CAN BE DISCONTINUED? ADDENDUM: After six months of reviewing in QA, and all allegations have been sufficiently investigated and reported to ISDH, and the committee feels there have been no allegations or incidents that were overlooked or missed, then the monitoring will be discontinued. All allegations or incidents will also be reviewed each month by the Clinical Support Nurse for approval.	

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	indicated she did not report the incident because she did not think it was a reportable occurrence. The Executive Director indicated she believed Resident #80 and CNA #9 were the only ones "talked to about this" and the issue was taken care of the same day it was reported. Interview of the DHS [Director of Health Services] on 08/17/12 at 11:00 a.m., regarding the incident involving Resident #80 and CNA #9, indicated the incident was reported to the DON "I believe" the next day by the Social Services Director. The DHS indicated she did not interview any other residents and she did not report the incident to ISDH. The DHS indicated she believed she talked to other CNAs but did not document it. During initial observation tour of the Residential section of the facility on 08/20/12 at 10:00 a.m. with the DHS [Director of Health Services] the DHS indicated Resident #80 was alert and oriented and very reliable for interview. Resident #80 resided on the certified section of the facility at the time of the incident. A copy of a form titled "Resident Concern Form" was provided by the DON on 08/15/12 at 1:30 p.m. The			

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	form was dated 04/25/12. The form indicated, "....Resident (Resident #80) said she wanted to get up yesterday & no one helped her. She (Resident #80) said she talked c [with] CNA (CNA #9) and per res [Resident #80] CNA told her I didn't get you up because you didn't want to get up yesterday. Resident told her she did get up (yesterday) & CNA said no, you didn't. Res feels like CNA was calling her a liar. " A picture of a face on the form was circled. The picture depicted an unhappy face with the words "Upset" and "Tearful" underneath the picture. The form indicated, "I (the Social Services Director) committed to: Letting the DHS [Director of Health Services] know so she could speak c [with] CNA. What should we do so this situation does not reoccur? The Resident told this to [name of Rehab Technician #1] in Rehab who passed it on to me." The form indicated, "Resolution and Communication to Resident...face to face...I spoke c Resident [Resident #80] last night and she does not want anything to come of this. She said everything worked out. Resident got up and she feels somehow they got off on the wrong foot. Resident does not want to talk to anyone else further about this....Spoke with [name of CNA]			

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	(CNA #9) on 2 occasions pertaining this." This statement was signed by the DHS [Director of Health Services]. A form titled "Abuse and Neglect Procedural Guidelines" was provided by the Executive Director on 08/15/12 at 9:55 a.m. The form had a revision date of 09/16/11. The form indicated, "Purpose: Trilogy Health Services, LLC (THS), has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect.....Definitions: a. ABUSE means the willful infliction of injury, unreasonable confinement, intimidation,....pain or mental anguish (known and/or alleged)....b. VERBAL ABUSE - may include oral, written or gestured language that includes disparaging and derogatory terms to the resident/patient or within their hearing distance....Staff to resident - any episode..." 3.1-28(a)			

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record	F0225	F 0225 CORRECTIVE ACTIONS	09/20/2012

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	review, the facility failed to ensure a resident's and a staff's allegation of abuse was thoroughly investigated and reported to the appropriate officials. This affected 1 of 3 residents reviewed for abuse. (Resident #80) Findings Include: Interview of Rehab Technician #1 on 08/14/12 at 11:20 a.m. indicated she was aware of an incident a few months ago which involved a CNA arguing with a resident (Resident #80) and causing the resident to be upset and tearful. The Rehab Technician indicated the CNA still worked at the facility. The Rehab Technician indicated she immediately reported the incident to her supervisor. Interview of Rehab Technician #1 on 08/14/12 at 1:21 p.m. indicated the incident was brought to her attention when she (Rehab Technician #1) went to get Resident #80 to take her for therapy. The Rehab Technician #1 indicated the CNA (CNA #9) had argued with Resident #80 about getting out of bed for breakfast. The Rehab Technician indicated, "[CNA#9] started arguing with the resident [Resident #80] in front of me about getting out of bed. It wasn't a		ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: Resident #80 is now residing on Assisted Living and has been revisited by Social Services to ensure there is no negative outcomes from the incident between her and the CNA when she resided on Health Center. Resident #80 is very Alert and Oriented now, and was at the time of the incident with the CNA and was very capable of making decisions for herself and answering questions. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN: all residents have the potential to be affected by the same alleged deficient practice.MEASURES PUT IN PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Support Clinical Nurse will review the campus guidelines of Abuse and Neglect with emphasis on investigation and required time frames for reporting, with the Leadership Team, including the ED, DHS, and ADHS. Then, the ED or designee will review the campus guidelines of Abuse and Neglect with staff. HOW THE	

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	loud yell - just an uncomfortable banter between the resident & [CNA #9]. I remember the CNA just left and I took [name of resident] to therapy. I had to take time to settle [name of resident] down because she was crying. [Name of resident] begged me not to report it. I (Rehab Technician #1) reported to my boss immediately & she told me to report it to [name of Social Services Director]. I did a verbal report & [name of the Social Services Director] followed up with [name of the resident]." The Rehab Technician indicated a week or two later, the DON stopped her in the hallway and asked her about the incident. Interview of the Executive Director on 08/15/12 at 11:50 a.m. indicated she was not involved in the investigation of the incident between CNA #9 and Resident #80. The Executive Director indicated the DHS [Director of Health Services] did the investigation and she (the Executive Director) signed off on it. The Executive Director indicated she did not report the incident because she did not think it was a reportable occurrence. The Executive Director indicated she believed Resident #80 and CNA #9 were the only ones "talked to about this" and the issue was taken care of		CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:ED or designee will conduct resident and staff interviews regarding Abuse and Neglect, specifically to verbal abuse, resident protection and reporting. Three resident and three staff interviews will be completed weekly for 60 days, then monthly for 4 months to ensure compliance. These interviews will be presented to the monthly Quality Assurance Committee for 6 months for further recommendations. WHAT WILL QA MONITOR BEYOND THE 6 MONTHS OF RESIDENT AND STAFF INTERVIEWS? ADDENDUM: The facility will investigate all allegations of abuse, file initial reports with ISDH, and follow up reports when applicable. Company Policy and Procedure will be followed, and employees with allegations of abuse against them will be suspended pending investigation, and terminated, if the findings deem that action is necessary. This will be an ongoing process that will be reviewed in QA each month. Also the Clinical Support Nurse will review each allegation during the investigation process. The facility will hold quarterly inservices on abuse for 1 year.	

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	the same day it was reported. Interview of the DHS [Director of Health Services] on 08/17/12 at 11:00 a.m., regarding the incident involving Resident #80 and CNA #9, indicated the incident was reported to the DON "I believe" the next day by the Social Services Director. The DHS indicated she did not interview any other residents and she did not report the incident to ISDH. The DHS indicated she believed she talked to other CNAs but did not document it. During initial observation tour of the Residential section of the facility on 08/20/12 at 10:00 a.m. with the DHS [Director of Health Services] the DHS indicated Resident #80 was alert and oriented and very reliable for interview. Resident #80 resided on the certified section of the facility at the time of the incident. A copy of a form titled "Resident Concern Form" was provided by the DON on 08/15/12 at 1:30 p.m. The form was dated 04/25/12. The form indicated, "....Resident (Resident #80) said she wanted to get up yesterday & no one helped her. She (Resident #80) said she talked c [with] CNA (CNA #9) and per res [Resident #80] CNA told her I didn't get you up			

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	155712	A. BUILDING 00 B. WING	08/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVERED BRIDGE HEALTH CAMPUS	1675 W TIPTON ST SEYMOUR, IN 47274

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	because you didn't want to get up yesterday. Resident told her she did get up (yesterday) & CNA said no, you didn't. Res feels like CNA was calling her a liar. " A picture of a face on the form was circled. The picture depicted an unhappy face with the words "Upset" and "Tearful" underneath the picture. The form indicated, "I (the Social Services Director) committed to: Letting the DHS [Director of Health Services] know so she could speak c [with] CNA. What should we do so this situation does not reoccur? The Resident told this to [name of Rehab Technician #1] in Rehab who passed it on to me." The form indicated, "Resolution and Communication to Resident...face to face...I spoke c Resident [Resident #80] last night and she does not want anything to come of this. She said everything worked out. Resident got up and she feels somehow they got off on the wrong foot. Resident does not want to talk to anyone else further about this....Spoke with [name of CNA] (CNA #9) on 2 occasions pertaining this." This statement was signed by the DHS [Director of Health Services]. A form titled "Abuse and Neglect Procedural Guidelines" was provided by the Executive Director on 08/15/12			

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	at 9:55 a.m. The form had a revision date of 09/16/11. The form indicated, "Purpose: Trilogy Health Services, LLC (THS), has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect.....Definitions: a. ABUSE means the willful infliction of injury, unreasonable confinement, intimidation,....pain or mental anguish (known and/or alleged)....b. VERBAL ABUSE - may include oral, written or gestured language that includes disparaging and derogatory terms to the resident/patient or within their hearing distance....Staff to resident - any episode....Protection - Upon identification of suspected abuse or neglect, immediately provide for the safety of the resident and the person reporting to maintain anonymity as reasonable and necessary. This may include, but is not limited to the following:....Suspend suspected employee(s) pending outcome of investigation...Investigation - The Executive Director is accountable for investigating and reporting....Reporting....Immediately and not more than 24 hours complete an initial report to applicable state agencies....A written report of the investigation outcome, including			

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	resident response and/or condition, final conclusion and actions taken to prevent reoccurrence, will be submitted to the applicable State Agencies within 5 days...." A form titled "Guidelines for Investigation Folder" was provided by the Executive Director on 08/15/12 at 2:40 p.m. The form was dated "11/2010." This form indicated, "Purpose: To provide guidelines on completing an investigation of accidents and incidents and compiling the information into an organized folder....Procedure:...An accident or incident should be thoroughly investigated to determine the root cause and implement interventions and approaches to mitigate the risk of occurrence...The investigation should include but may not be limited to: a. Review of the Circumstance and Reassessment form. b. Review of nursing notes. c. Interview of witnesses to the incident." 3.1-28(c) 3.1-28(d) 3.1-28(e)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure policies and procedures for reporting and investigating allegations of abuse were followed for 1 of 3 residents reviewed for an abuse allegation. (Resident #80) Findings Include: Interview of Rehab Technician #1 on 08/14/12 at 11:20 a.m. indicated she was aware of an incident a few months ago which involved a CNA arguing with a resident (Resident #80) and causing the resident to be upset and tearful. The Rehab Technician indicated the CNA still worked at the facility. The Rehab Technician indicated she immediately reported the incident to her supervisor. Interview of Rehab Technician #1 on 08/14/12 at 1:21 p.m. indicated the incident was brought to her attention when she (Rehab Technician #1) went to get Resident #80 to take her for therapy. The Rehab Technician	F0226	F 0226 CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: Follow up visit made to resident #80, who is now a resident on Assisted Living. She has suffered no negative outcomes from the experience with CNA on Health Center, and is very satisfied with care here and has even recommended the campus to her sister, who is also now a resident on Assisted Living. The CNA has since been terminated following a reportable incident that happened during the residential portion of our annual survey.IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN: All residents have the potential to be affected by the same alleged deficient practice.The facility will continue to implement all aspects of the abuse policy and procdures including screening, training, prevention, identification, protection, investigation,	09/20/2012

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	#1 indicated the CNA (CNA #9) had argued with Resident #80 about getting out of bed for breakfast. The Rehab Technician indicated, "[CNA#9] started arguing with the resident [Resident #80] in front of me about getting out of bed. It wasn't a loud yell - just an uncomfortable banter between the resident & [CNA #9]. I remember the CNA just left and I took [name of resident] to therapy. I had to take time to settle [name of resident] down because she was crying. [Name of resident] begged me not to report it. I (Rehab Technician #1) reported to my boss immediately & she told me to report it to [name of Social Services Director]. I did a verbal report & [name of the Social Services Director] followed up with [name of the resident]." The Rehab Technician indicated a week or two later, the DON stopped her in the hallway and asked her about the incident. Interview of the Executive Director on 08/15/12 at 11:50 a.m. indicated she was not involved in the investigation of the incident between CNA #9 and Resident #80. The Executive Director indicated the DHS [Director of Health Services] did the investigation and she (the Executive Director) signed off on it. The Executive Director		reporting.MEASURES PUT IN PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Support Clinical Nurse will review the campus guidelines of Abuse and Neglect, with focus on investigation, with the Leadership team, including the ED, DHS, and ADHS. Then, the ED or designee will review the campus guidelines of Abuse and Neglect with staff. HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:ED or designee will conduct resident and staff interviews regarding Abuse and Neglect, specifically to verbal abuse, resident protection, and reporting. Three resident and three staff interviews will be completed weekly for 60 days, then monthly for 4 months to ensure compliance. The interviews will be presented to the monthly Quality Assurance Committee for six months for further recommendations.	

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	indicated she did not report the incident because she did not think it was a reportable occurrence. The Executive Director indicated she believed Resident #80 and CNA #9 were the only ones "talked to about this" and the issue was taken care of the same day it was reported. Interview of the DHS [Director of Health Services] on 08/17/12 at 11:00 a.m., regarding the incident involving Resident #80 and CNA #9, indicated the incident was reported to the DON "I believe" the next day by the Social Services Director. The DHS indicated she did not interview any other residents and she did not report the incident to ISDH. The DHS indicated she believed she talked to other CNAs but did not document it. During initial observation tour of the Residential section of the facility on 08/20/12 at 10:00 a.m. with the DHS [Director of Health Services] the DHS indicated Resident #80 was alert and oriented and very reliable for interview. Resident #80 resided on the certified section of the facility at the time of the incident. A copy of a form titled "Resident Concern Form" was provided by the DON on 08/15/12 at 1:30 p.m. The			

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	form was dated 04/25/12. The form indicated, "....Resident (Resident #80) said she wanted to get up yesterday & no one helped her. She (Resident #80) said she talked c [with] CNA (CNA #9) and per res [Resident #80] CNA told her I didn't get you up because you didn't want to get up yesterday. Resident told her she did get up (yesterday) & CNA said no, you didn't. Res feels like CNA was calling her a liar. " A picture of a face on the form was circled. The picture depicted an unhappy face with the words "Upset" and "Tearful" underneath the picture. The form indicated, "I (the Social Services Director) committed to: Letting the DHS [Director of Health Services] know so she could speak c [with] CNA. What should we do so this situation does not reoccur? The Resident told this to [name of Rehab Technician #1] in Rehab who passed it on to me." The form indicated, "Resolution and Communication to Resident...face to face...I spoke c Resident [Resident #80] last night and she does not want anything to come of this. She said everything worked out. Resident got up and she feels somehow they got off on the wrong foot. Resident does not want to talk to anyone else further about this....Spoke with [name of CNA]			

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	(CNA #9) on 2 occasions pertaining this." This statement was signed by the DHS [Director of Health Services]. A form titled "Abuse and Neglect Procedural Guidelines" was provided by the Executive Director on 08/15/12 at 9:55 a.m. The form had a revision date of 09/16/11. The form indicated, "Purpose: Trilogy Health Services, LLC (THS), has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect.....Definitions: a. ABUSE means the willful infliction of injury, unreasonable confinement, intimidation,....pain or mental anguish (known and/or alleged)....b. VERBAL ABUSE - may include oral, written or gestured language that includes disparaging and derogatory terms to the resident/patient or within their hearing distance....Staff to resident - any episode....Protection - Upon identification of suspected abuse or neglect, immediately provide for the safety of the resident and the person reporting to maintain anonymity as reasonable and necessary. This may include, but is not limited to the following:....Suspend suspected employee(s) pending outcome of investigation...Investigation - The			

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	Executive Director is accountable for investigating and reporting....Reporting....Immediately and not more than 24 hours complete an initial report to applicable state agencies....A written report of the investigation outcome, including resident response and/or condition, final conclusion and actions taken to prevent reoccurrence, will be submitted to the applicable State Agencies within 5 days...." A form titled "Guidelines for Investigation Folder" was provided by the Executive Director on 08/15/12 at 2:40 p.m. The form was dated "11/2010." This form indicated, "Purpose: To provide guidelines on completing an investigation of accidents and incidents and compiling the information into an organized folder....Procedure:...An accident or incident should be thoroughly investigated to determine the root cause and implement interventions and approaches to mitigate the risk of occurrence...The investigation should include but may not be limited to: a. Review of the Circumstance and Reassessment form. b. Review of nursing notes. c. Interview of witnesses to the incident." 3.1-28(a)			

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on interview, the facility failed to ensure a resident (#35) was treated with dignity. The facility answered her call light, turned if off, then did not return before she had an incontinent episode of bowel, for 1 of 23 residents interviewed regarding staff response to requests for assistance. Findings Include. During interview with Resident # 35 on 8/15/12 at 2:20 p.m., the resident indicated a staff member had come into her room after she put on the call light, she asked to use the restroom, and the staff member then shut the light off and said they would be right back, but they never did, causing Resident # 35 to have an incontinent episode of her bowels. Regarding the amount of times in past month the staff said they would be right back and did not do so, Resident #35 indicated that this happened a few times. Resident #35	F0241	F 0241 CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: Establish toileting pattern and develop plan of care based on toileting pattern. CNA assignment sheet updated to reflect sense of urgency related to loose stools. Interview resident by ADHS on 9-12-12, stated that she has had no further problems with incontinent episodes. Everyone answers her call light timely and helps her when she needs them. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN: All residents have the potential to be affected by the alleged deficient practice. ED or designee will continue to meet with Resident Council on Health Center and Assisted Living monthly (if agreeable with the residents) to determine if there are any issues with call lights or staff, or related problems MEASURES PUT IN PLACE AND SYSTEMIC	09/20/2012

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	was asked if she had any accidents when this occurred, and she stated yes, but she had been having trouble with loose bowels and the medications she was receiving was helping. The resident stated this had happened during the day around lunch time. During interview on 8/17/12 at 2:50 p.m., QMA #2 indicated she was not aware of Resident #35's call light not being answered in a timely manner. She stated that she was aware Resident # 35 was having some loose stools. 3.1-3(t)		CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Staff will be inserviced on 9-11 and 9-12 on answering call lights in a timely manner, and making sure that call lights are not turned off until they have taken care of the residents' needs. HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Interviews will be done by DHS or designee to ensure compliance. 3 resident interviews will be done weekly for 60 days, then 3 resident interviews will be done monthly for 4 months. All interviews will be brought to Quality Assurance Committee for further recommendations. HOW LONG WILL QA MONITOR MEASURES? WHAT CRITERIA USED TO DETERMINE MONITORING CAN BE DISCONTINUED?ADDENDUM: QA will monitor the interviews of the residents done by the DHS or designee, for six months. If, after 6 months, there have been no further issues with call lights being turned off, and residents have no complaints of not having needs met in a timely manner, then monitoring will be discontinued by the QA committee. If issues arise during the interview process, every effort will be made to determine the individual person, so that 1:1	

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			counseling can be done with them. If that is not possible, then an inservice will be held for all staff to re-educate them.	

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F0248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to provide activities designed to meet the residents' needs, in accordance with the comprehensive assessment and interests of each resident, for 2 of 4 residents reviewed for activities of 14 who met the criteria for activities. Residents #5 and #26 Findings include: 1.) Resident #26's clinical records were reviewed on August 15, 2012 at 2:40 p.m. Resident #26's diagnoses included, but were not limited to, Parkinson's disease [a chronic degenerative disease of the central nervous system that produces movement disorders and changes in cognition and mood], deconditioning, weakness, cerebrovascular accident with hemiparesis [a stroke with loss of purposeful movement on one side of the body], dementia with agitation, and depression.	F0248	F 0248 CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: The activity calendar was updated to include current activity preferences of Resident #26 and Resident #5. A meeting was held by the Activity Director with the Hospice representative regarding their coordination of care to allow resident's participation in activities of interest. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN: All residents have the potential to be affected by this alleged deficient practice. Careplans for residents on hospice and those needing assistance to the activity were reviewed to ensure current activity preferences for structured activities were identified and activity logs indicate attendance. MEASURES PUT IN PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE	09/20/2012

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	The most recent Minimum Data Set Assessment dated June 04, 2012; indicated Resident #26 understood others with clear comprehension and others understood him. A BIMS score [a brief screener that aids in detecting cognitive impairment] indicated Resident #26 was cognitively intact. A Resident Preference for Customary Routine and Activities Work Sheet dated May 22, 2012; [most recent assessment] indicated, "Recreational Interest: Cards/Games/bingo, Exercise/Sports, Talking/Conversing, Socializing/Parties, Watching TV, Fishing/Hunting (past). Preferred time to participate in an activity program: Morning, Afternoon." Resident #26's current Care Plan indicated, "Focus. _____ [Resident #26's name] is alert and oriented to choosing his own leisure daily, with some cues to times and locations of group activities. ... Interests include: Musical Programs, Happy Hour Exercise, some outdoor activities, social events. Goal: _____ [Resident #26's name] will actively participate in 3 - 5 social activity groups weekly (including exercise, Happy Hour, and music programs) to enhance quality of life. _____ [Resident #26's name]		ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Activity staff will be inservice by Activity Support staff on the need to identify Activity preferences of residents, how to ensure residents are invited to appropriate, preferred activities, and how to document that. HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:The Activity Director or designee will audit the monthly calendar each month for the next 12 months to ensure residents interests are addressed. The audits will be presented to the monthly Quality Assurance Committee for further recommendations. The Activity Director or designee will audit the Daily Participation Log five times per week for 60 days, then monthly for 4 months to ensure residents have been invited to, and provided with, structured activities consistent with preferences. This audit as well, will be presented to the monthly to the Quality Assurance Committee for 6 months for further recommendations.	

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	will also participate in 3 - 4 premeal activities weekly for cognitive stimulation. Interventions [care staff implement to achieve goal] ... Invite/encourage/escort to mentally stimulating programs of interest as they occur as needed and desired. - reminisce, spelling bees, current events, word puzzles etc. ..." Review of the August 2012 Activity Calendar indicated on Monday August 13, 2012 at 10:00 a.m.; "Morning Stretches - On the Patio." At 10:30 a.m. "Washer games - Patio." On August 13, 2012; Resident #26 was observed in his room during the scheduled activities. On August 14, 2012 at 9:30 a.m.; Resident #26 was taken from the dining room to his room. At 9:35 a.m.; a staff was present outside of Resident #26's room, in the hall. They were heard to invite residents to an activity. A staff member was observed to walk past Resident #26's room without having invited him to an activity. At approximately 9:40 a.m.; a second staff asked the first staff if she needed help with getting any resident(s) to activities. The first staff was heard to say, "I think I got			

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	everyone from down here." None of the staff were observed to enter Resident #26's room and ask him if he would like to come to activities. Review of the August 2012 Activity Calendar indicated Tuesday August 14, 2012 at 9:30 a.m.; was bingo and at 11:30 a.m. were jokes and riddles. Both of the scheduled activities took place in the Health Care Dining Room. Resident #26 remained in his room, during that time. August 15, 2012 at 10:17 a.m.; Resident #26 was in his room, with his spouse present. When asked about activities the resident would like to do, Resident #26's wife indicated, "We go to bingo sometimes." Resident #26 looked at his wife and said, "Well, I'd like to go home." Resident #26 and his wife then talked a bit about him having been a farmer and he liked to be outside. Review of the August 2012 Activity Calendar indicated Wednesday August 15 at 10:00 a.m. morning stretches, 11:30 a.m. good old days on the farm, and at 2:30 p.m. resident birthday party. Resident #26 was observed to not attend of any of these activities.			

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	Review of the August 2012 Activity Calendar indicated on Thursday August 16 at 9:30 a.m.; a bus cruise. Resident #26 was observed to not attend. On August 16, 2012 at 8:55 a.m.; C.N.A. #1 was asked about activities Resident #26 liked to attend. C.N.A. #1 indicated, "Bingo, happy hour on Friday afternoon, and he used to go on more outings, less the past two months. Oh, and he likes to read the paper [not observed in Resident #26's room]." C.N.A. #1 was asked about encouraging and assisting resident #26 to activities. C.N.A. #1 indicated when you ask him, "He just gives you a blank stare." On August 16, 2012 at 9:20 a.m.; the Director of Social Services was interviewed. During the interview the Social Service Director was asked about Resident #26. The Social Service Director indicated, "_____ [Resident #26's name] has had an overall physical decline the past month or two, due to his Parkinson's." The Social Service Director indicated Resident #26 was oriented and interviewable, "but very slow to answer questions." On August 16, 2012 at 9:40 a.m.;			

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	Resident #26 was observed to attend an unscheduled bingo game being played in the main dining room. On August 16, 2012 at 9:42 a.m.; the Activities Director was interviewed. During the interview the Activities Director indicated Resident #26 liked to attend, "bingo and music programs." The Activities Director was asked about Resident #26 not having attended the bus cruise. The Activities Director indicated Resident #26 had declined to attend on July 26, 2012 at 10:30 a.m.; for a bus trip to the Senior Center Lunch & Bingo, and has not gone out since then. Having indicated, "He is very quiet and doesn't say a whole lot." After the interview, the Activities Director provided a copy of Director of Resident Activities Expectations of Excellence dated July 13, 2009. The documented indicated, "When out in the Health Campus performing your duties always cheerfully and sincerely greet residents, families and fellow team members; using their name if possible. If a resident or family member needs assistance, help them get the assistance they need. Small details such as making eye contact and smiling are always appreciated! ..." The document lacked directions,			

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	which indicated to ask and assist residents to activities. 2) Resident #5's clinical records were reviewed on August 15, 2012 at 2:20 p.m. Resident #5's diagnoses included but were not limited to depression, malaise, fatigue, insomnia, renal insufficiency, and end stage congestive heart failure. A Resident Preference for Customary Routine and Activities Interview Work Sheet [non-dated/identified as initial, most recent assessment] indicated, "Recreational Interest: Crafts/Arts/Puzzles, work search, Talking, Socializing, Watching TV, Gardening/Plants. ... Other Important things to know about me: can answer some questions and very opinionated/independent." A Social Service Progress Note dated July 20, 2012 indicated; "... Family voiced ... did read a lot & no longer able to, may enjoy being read to ..." Resident #5's current Care Plan indicated, "Focus: _____ [Resident #5's name] was recently admitted to facility. Has a need to adjust to situation and life change. Goal: _____ [Resident #5's name] will express satisfaction with level and			

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	type of involvement when asked to facilitate adjustment. Interventions [care staff implement to achieve goal]: Provide monthly schedule of group programs. ... Assess resident's interests, abilities, and limitations...." On August 15, 2012 from 9:20 a.m. to 10:00 a.m.; Resident #5 was observed awake in bed. Resident #5 was observed to be lying in bed and looking into the hall, from her bed. Review of the August 2012 Activity Calendar indicated; August 15 at 10:00 a.m. "morning stretches." Resident #5 was observed to not attend. Continued observation on August 15, from 1:35 p.m. through 2:15 p.m.; Resident #5 was observed lying awake in bed looking out into the hall. At 1:35 p.m. Resident #5 was interviewed in her room. While in the room Resident #5 looked out her window at an empty bird feeder and said, "There are no birds." Resident #5 further indicated, "They are keeping me in here." On August 16, 2012 from 8:05 a.m. to 9:30 a.m.; Resident #5 was observed lying in bed awake, looking out into			

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	the hall. On August 16, 2012 at 8:55 a.m.; C.N.A. #1 was asked about Resident #5 being in bed. C.N.A. #1 indicated Resident #5 was recently transferred from the 200 hall within the past two weeks and she is still getting to know her. The CNA indicated Resident #5 is to lie down after meals, to rest. C.N.A. #1 was then asked about activities. C.N.A. #1 did know Resident #5 was able to verbalize what she wanted and didn't want. The CNA indicated Resident #5 liked mints, and she will say, "Mint please," and also enjoys bingo, paints, exercise, and Church on Sundays. On August 16, 2012 at 10:10 a.m. the Activities Director was interviewed. During the interview the Activities Director indicated Resident #5 liked to participate in activities. There was no mention of activities to do, while awake in her room, while lying in bed. 3.1-33(a)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure a physician order for a PT/INR (prothrombin time/international normalized ratio) (to monitor anticoagulation therapy) lab was obtained, for 1 of 10 residents reviewed for labs to monitor drug therapy. Resident #101 Findings include: Resident #101's clinical record was reviewed on 8/16/12 at 7:58 A.M. Diagnoses included, but were not limited to: hyperlipidemia, diabetes mellitus II, and ischemic heart disease. The resident was admitted to the facility on 7/28/12, following a hospital stay due to having fallen and hitting his head at home. Medications ordered on admission, included Coumadin 7 mg daily, a drug which thins the blood to prevent blood clots. A lab result sent from the hospital was Protime 26.8 H (high), normal 9.7	F0282	F 0282 CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: All new admissions orders will be reviewed in Clinical Morning Meeting Mon-Fri. A list will be requested from our pharmacy every two weeks, of all pending labs. That list will be cross referenced to lab results and the lab log to ensure all labs were completed in a timely manner. The lab ordered for resident #101 was obtained on 8-16 with physcian notified of results, there were no change in med orders, re-check pt/inr orders in one month. There was no negative outcome. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN: All residents on medications that require laboratory monitoring have the potential to be affected by this alleged defiecient practice. Lab monitoring for specified medications is completed thru the Clinical meeting process. MEASURES PUT IN PLACE	09/20/2012

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	to 12.3, and INR 2.57 H (high), normal range .95 to 1.11. A telephone physician order, dated 8/11/12, indicated PT/INR due on 8/11/12. During interview with the Unit Manager, RN # 1, on 8/16/12 at 8:30 A.M., she indicated the PT/INR due on 8/11/12, was "just missed." RN #1 indicated on 8/16/12 at 2 p.m. the labs had been sent and the resident had an appointment with his physician at 2:00 P.M. that same day. On 8/16/12 at 11:00 A.M. the DON (Director of Nursing) provided the lab results for Resident #101 dated 8/16/12. The results were prothrombin time 22.3 H (high) (normal range 9.7-12.3), and INR 2.12 H (high) (normal range .95 to 1.11) 3.1-35(g)(2)		AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Educate Licensed Nursing staff on transcription of lab orders with inservice on 9-11-and 9-13. HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Will audit TARS/Lab sheet twice per week to ensure labs are signed off and completed. HOW LONG WILL THE QA PROCESS GO ON? ADDENDUM: Nursing Administration Team reviews all lab orders including new admissions every morning in the clinical meeting, M-F to ensure all orders were transcribed appropriately. (on physician order sheet, personal lab sheet, daily audit sheet, and calendar for up coming labs). Also put on daily clinical follow up sheet for nursing to check on the next day. The monitoring of labs in QA is an ongoing process, and is done every month.	

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to coordinate care with hospice services to ensure the highest practicable psychosocial well being of a resident [Resident #5] and failed to coordinate care with the dialysis center [Resident #109] for 2 of 2 residents reviewed for receiving of special services. Findings include: 1) Resident #5's clinical records were reviewed on August 15, 2012 at 2:20 p.m. Resident #5's diagnoses included but were not limited to depression, malaise, fatigue, weight loss, insomnia, renal insufficiency, and end stage congestive heart failure. Physician orders dated May 24, 2012; indicated "May continue with [company name] Hospice." On August 13, 2012 at 9:20 a.m.; Resident #5 was observed to be	F0309	F 0309 CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: A meeting was held on August 17th by the Activity Director with the Hospice representative to negotiate the schedule on Resident #5's behalf to ensure that she is able to receive the care she needs from Hospice and also is allowed to attend the activities of her choice each day, without interruption. The Hospice agency was a new provider to our campus and the aide was new to our facility. Our campus will continue to coordinate care with all of our providers of Hospice care. Nurses responsible for completing communication form for outpatient dialysis on 8-7, 8-9, 8-11, and 8-14, will receive teaching moments from the DHS regarding the assessment pre and post dialysis. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND	09/20/2012

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	awake, lying in bed. Resident #5 indicated, "I'm sick and tired of staying in bed, I want to get up and run around with the rest of them." When asked what she'd like to do, she mentioned activities but was unable because her hospice aide was coming. Review of the August 2012 activities calendar for Monday the 13th indicated, " 10:00 a.m. Morning Stretches - on the Patio." Continued observation on August 13, just before 10:00 a.m.; Resident #5's hospice aide arrived. The hospice aide indicated she comes three times a week: on Monday, Wednesday, and Friday at 10:00 a.m. to provide assistance with a bath and/or shower. Review of the August 2012 activities calendar for Wednesday the 15th indicated, "10:00 a.m. morning stretches." Resident #5 was in attendance. During observation on August 15, 2012 at 10:10 a.m., the hospice aide entered the activity room and removed the resident. The hospice aide was heard to say, "Its time to get washed up" and then wheeled the resident out into the hall.		CORRECTIVE ACTIONS TAKEN: Any residents on Hospice or Dialysis have the potential to be affected by this alleged deficient practice.One other resident was identified in house for completion of dialysis form. Residents record will be audited by 9-20 for completion of pre and post dialysis assessment. MEASURES PUT IN PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Education for all nurses on documention on dialysis residents, pre and post dialysis will be done by DHS by 9-20-12. HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Audit will be done on pre and post dialysis assessment form 3 times per week for 60 days and then 1 time per month for 4 months to ensure compliance. All audits will be reviewed by monthly Quality Assurance Committee for further recommendations. HOW LONG WILL QA MONITOR THE MEASURES? WHAT CRITERIA WILL DETERMINE MONITORING CAN BE DISCONTINUED?ADDENDUM: QA committee will monitor audits on dialysis assessment forms for 6 months. If in compliance at the end of six months, or there are no	

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	On August 16, 2012 at 8:55 a.m.; C.N.A. #1 was interviewed. C.N.A. #1 indicated Resident #5 was recently transferred from 200 hall, within the past two weeks. Resident #5 is able to verbalize what she wants and doesn't want. C.N.A. #1 was unsure about the hospice aide's schedule, did know they came on Mondays and Wednesdays in the morning. Resident #5's current Care Plan indicated, "Problems: Depression, Depression or at risk for depression ... Hospice Social Worker in place, to visit c [with] resident weekly. Interventions [care staff is to implement to prevent/reduce depression ... Encourage participation in activities of choice and interest." On August 16, 2012 at 12:40 p.m.; the Activities Director was interviewed. During the interview, the Activities Director did not know Resident #5 was being removed from activities to receive services from hospice. The Activity Director indicated she would talk with hospice staff to prevent recurrence. That they could work with schedules to allow Resident #5 to attend activities. On August 17, 2012 at 10:25 a.m.;		dialysis residents residing in the facility, QA monitoring will be discontinued.	

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	the Activities Director provided documentation which indicated, "Friday, August 17th, hospice aide attending to [Resident #5's name] reported to me and we were able to work out a time for Resident #5's name] to receive her care and attend activities." 2. Review of Resident #109's clinical record on 08/17/12 at 10:00 a.m. indicated the following: A physician's telephone order dated, 08/09/12 at 1:30 p.m., indicated, " Take BP [blood pressure] twice daily and sent (sic) report c [with] res [Resident #109] to next dialysis appt. [appointment]." A physician's re-write order for August, 2012 indicated Resident #109 had diagnoses which included, but were not limited to, anxiety, hyponatremia, acute renal failure, aspiration pneumonia, anemia, encephalopathy, hypocalcemia, hypermagnesiumemia, Vitamin D deficiency, and history of Lyme disease. Interview of RN #3 on 8/16/12 at 2:20 p.m. indicated nursing staff checked Resident #109's blood pressure daily and results are sent with the resident for her dialysis treatments.			

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	A Consultation Report dated 07/23/12, indicated "Reason for consultation: Kidney failure and assessment for need for dialysis, hyponatremia and hypocalcemia.... [Resident #109's name] presents with a 3 week 'flu like' presentation including fevers, chills, aching....In the emergency room, she was found to be profoundly hyponatremic with sodium of 104....The patient was also found to be in kidney failure with a BUN of 135,kk creatinine 8.1....During hospitalization, the systolic blood pressure has ranged between 140 to 170 mmHG. Assessment and Plan: Renal failure, hypovolemic with symptomatic hyponatremia, hypocalcemia, severe anemia, dehydration....At this point the patient likely needs dialysis...." Consultation Report - 07/23/12 - Reason for consultation: Kidney failure and assessment for need for dialysis, hyponatremia and hypocalcemia....[Resident #109's name] presents with a 3 week "flu like" presentation including fevers, chills, aching....In the emergency room, she was found to be profoundly hyponatremic with sodium of 104....The patient was also found to be in kidney failure with a BUN of			

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	135, creatinine 8.1....During hospitalization, the systolic blood pressure has ranged between 140 to 170 mmHG. Assessment and Plan: Renal failure, hypovolemic with symptomatic hyponatremia, hypocalcemia, severe anemia, dehydration....At this point the patient likely needs dialysis...." Resident #109 was admitted to the facility on 08/06/12. Admitting orders dated 08/06/12 indicated Resident #109 received dialysis treatments on Tuesday, Thursday, and Saturday at 11:00 a.m. A nurse's note,dated 08/14/12 at 8:30 p.m. indicated, "Res [Resident #109] c/o headache at 7 PM. PRN [as needed] Tylenol given at this time. Res now c/o headache persisting now c [with] chest pain that radiates down (L) [left] arm/shoulder et nausea [symbol for without] vomiting. MD [name of MD] notified et orders to send to ER for eval [evaluation] et tx. res refuses to go via ambulance but will go via private care c friend at bedside...." A nurse's note, dated 08/16/12 at 5:00 p.m. indicated, "Readmitted via facility bus c CBHC [Covered Bridge Health Campus] staff. All original			

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	orders to continue. Res A&O [alert and oriented]....res wt [weight] 92.6, V/S [vital signs] (blood pressure) 120/68, (heart rate) 91, (oxygen saturation) 96%, (temperature) 97.7, (respirations) 17. A communication form book for dialysis was noted to have pages for 08/14 and 08/16. Resident #109 had dialysis on 08/07, 08/09, 08/11, and 08/14. The pages in the communication form book were titled "Communication Form for Outpatient Dialysis Units." The first column of the form was for the facility to place information regarding Resident #109 before she was sent out for dialysis. The form indicated Resident #109's weight, blood pressure, temperature, pulse, respiration rate, Bruit-Thrill of shunt site, and shunt site assessment were to be sent with the resident prior to her dialysis treatments. The column under 08/14/12 for the facility's documentation of the resident's weight and shunt site assessment prior to her dialysis were blank and the column for the facility's assessment after the resident's return from dialysis lacked documentation supporting the resident's weight, blood pressure, temperature, pulse, respirations, and shunt site were			

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	assessed after the resident returned from dialysis. The facility failed to provide documentation supporting assessments prior to and after dialysis were performed by the facility on 08/07, 08/09, 08/11, and 08/14. The facility failed to provide documentation supporting that a care plan had been created for a resident in renal failure and receiving dialysis 3 times weekly. Interview of the Consultant RN on 08/17/12 at 8:00 a.m. indicated the facility communicates with the Dialysis by form kept in dialysis book. The Consultant RN indicated there was supposed to be a form for each day resident #109 goes out to dialysis. The dialysis book only had assessments for 2 days and these assessments were incomplete. Interview of RN #1 on 08/17/12 at 11:00 a.m. indicated the facility fills out area under "campus" and include anything pertinent i.e. if Resident #109 had a PRN medicine, if she was nauseated and when the resident gets to dialysis the dialysis center fills out their section and add notes or any new orders. RN #1 indicated the resident gets Epogen (often used to treat anemia in patients who are in			

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	renal failure and receiving dialysis) each dialysis treatment. Upon return, facility documents in the other "Campus" column to assess the resident after she returns from dialysis. The facility failed to provide documentation supporting resident assessments were completed after she returned from the dialysis center. 3.1-37(a)			

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F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.			
	Based on observation, interview, and record review, the facility failed to ensure a resident who is incontinent of bladder received the appropriate services to restore as much normal bladder function as possible for 1 of 1 resident reviewed for urinary incontinence of 2 who met the criteria for urinary incontinence. Resident #26 Findings include: 1.) Resident #26's clinical records were reviewed on August 15, 2012 at 2:40 p.m. Resident #26's diagnoses included, but were not limited to, Parkinson's disease [a chronic degenerative disease of the central nervous system that produces movement disorders and changes in cognition and mood], deconditioning, weakness, urinary incontinence and	F0315	F 0315 CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: Resident #26 is currently in the hospital and will be reassessed upon return to campus. Due to deteriorating physical and fluctuating mental status, the careplan will be updated to reflect the current assessment. Resident is not currently capable of utilizing a urinal. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN: All male residents have the potential to be affected by this alleged deficient practice. All male residents on Health Center will be evaluated for a urinal at bedside by 9-20-12. MEASURES PUT IN PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE	09/20/2012

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	cerebrovascular accident with hemiparesis [a stroke with loss of purposeful movement on one side of the body]. The most recent Minimum Data Set Assessment dated June 04, 2012; indicated Resident #26 understood others with clear comprehension. A BIMS score [a brief screener that aids in detecting cognitive impairment] indicated resident #26 was cognitively intact, was incontinent of bladder with no toileting program, and was dependent on staff for toileting needs. Interview on August 14, 2012 at 11:40 a.m.; with Resident #26's spouse indicated a voiced concern that the resident is no longer provided a urinal for toileting needs. Resident #26's current Care Plan indicated, "Problems: Incontinence .. Interventions [care nursing staff implement to reduce episodes of incontinence] ... provide a urinal for him [in large bold print]." Observation of Resident #26, during the day(s) of August 13, 14, 15, and 16, 2012; a urinal was not provided, nor offered. Resident #26 was observed to wear a brief and be provided incontinence care.		ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:The nursing administration team in their Clinical Meeting reviews elimination status of residents, changes in status, which would include ability to use a urinal, will be addressed with care plan changes implemented. Changes will be communicated via the nurse aid assignment sheets updates. HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Audit 3 residents weekly for 6 months for care plan interventions regarding use of urinals and devices and that urinal is at bedside. Audits will be reviewed by Quality Assurance Committee monthly for 6 months for further recommendations. WHAT SYSTEMS MEASURES TAKEN TO ENSURE NURSING DOESN'T REPEAT THE NONCOMPLIANCE I.E.; INSERVICE?ADDENDUM: Nursing Administrative Team will assess all new admissions and current male residents for use of urinals. On 9-25-12 and 9-27-12 inservices will be held to re-educate all nursing staff to keep urinals within reach of residents, and ensure it is care planned and on the CNA assignment sheets. During daily rounding, if issues are found regarding the urinals not being	

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	On August 16, 2012 at 8:55 a.m.; C.N.A. #1 was asked about Resident #26 being provided use of a urinal. C.N.A. #1 indicated, "Offer a urinal, oh yes, last time he tried, he dumped it everywhere. Wanted to try to do it himself." C.N.A. #1 further indicated that was a "Few weeks back," and since then has not had the urinal. 3.1-41(a)(2)		within reach, 1:1 education will be done with staff at that time.	

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F0323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the residents' environment remained free of accident hazards to prevent falls and/or injury for 2 of 4 residents reviewed for accidents of 7 who met the criteria for accidents, in that a call light and personal items were not positioned within reach [Resident #26], and failed to ensure a resident's bed was positioned in a manner that would prevent a gap between the wall and side of the bed [Resident # 50]. Findings include: 1.) Resident #26's clinical records were reviewed on August 15, 2012 at 2:40 p.m. Resident #26's diagnoses included, but were not limited to Parkinson's disease [a chronic degenerative disease of the central nervous system that produces movement disorders and changes in cognition and mood], deconditioning, weakness, and cerebrovascular accident with hemiparesis [a stroke	F0323	F 0323 CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: Resident #26 is currently in hospital upon return will be reassessed due to physical deterioration and fluctuating mental status. Use of the reacher will be re-evaluated upon his return. Resident #50 agreed to have bed moved to prevent gap between wall and bed, and explanation was given to the resident regarding safety precautions on why the bed needed to be moved farther from the wall. Fall mat was discontinued on resident #50 also. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN: All residents have the potential of being affected by this alleged deficient practice. The campus will continue to utilize prevention statagies for incidents and accidents based on the individualized assessment and	09/20/2012

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	with loss of purposeful movement on one side of the body]. The most recent Minimum Data Set Assessment dated June 04, 2012; indicated Resident #26 understood others with clear comprehension. A BIMS score [a brief screener that aids in detecting cognitive impairment] indicated Resident #26 was cognitively intact. The assessment further indicated no history of falls. Resident #26 was dependent on nursing staff for mobility. Licensed Staff's documentation in Resident #26's Nurse's Notes dated August 04, 2012 at 8:00 p.m. indicated, "Observed res [resident] lying on floor in res room. ... Noticed abrasion [a scraping away of the skin] on L [left] side of forehead. ... Res stated 'taking off shoes.' ..." A Fall Circumstance, Assessment and Intervention Form dated August 04, 2012 at 8:00 p.m. indicated, "Found on floor ... root cause: Trying to take shoes off & fell forward out of w/c [wheelchair]." On August 15, 2012 11:05 a.m., Physical Therapy staff #1 came to Resident #26's room to implement an evaluation, due to a fall on August 04,		careplan. All incidents will be investigated, tracked, trended and reported when applicable. MEASURES PUT IN PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Maintaining personal items in reach will be monitored daily during rounds. Variations from compliance will be reported daily to ED or designee and monthly to Quality Assurance Committee for further recommendations. HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:All staff will be educated on maintaining resident #26 personal items within his reach at inservice to be held by 9-20-12. Fall interventions will continue to be assessed quarterly and with change of condition for appropriate use.HOW LONG WILL QA MONITOR THE CORRECTIVE MEASURES? ADDENDUM: QA will monitor for six months. If any issues regarding personal items not within reach are discovered during rounds, they will be corrected at that time, and staff will be re-educated. If, after 6 months, no further issues have been noted during rounding, then QA will discontinue monitoring.	

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	2012. Physical Therapy staff #1 indicated the evaluation was due to Resident #26 having, "scooted right out to the floor," and also indicated, staff reported Resident #26 "leaned forward while seated in his wheelchair and fell." Resident #26's current Care Plan indicated; "Problems: Falls, history of falls, potential for fall ... Interventions [care staff implement to reduce risk for fall] Provide environmental adaptations: ... call light within reach ... reacher placed in easy reach ... place frequently used items within reach / Kleenex box ..." During observation on August 15, 2012 at 9:35 a.m., Resident #26 was in his room, positioned in the center of the room, between bed A and bed B, in his wheelchair. The resident's bedside table with personal items was positioned on the outside of bed B, beside the window. The call light was attached to the lower area of the wheelchair. Bedside water was positioned on a dresser, beyond his reach. On August 15, 2012 at 9:42 a.m., RN #3 was asked about Resident #26's call light and placement of personal items. RN #3 repositioned the call			

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	light to within Resident #26's reach, having indicated staff must have clipped the call light to the transfer pad and then the pad must have slipped down below the seat of the wheelchair. RN #3 then positioned Resident #26's bed side table beside him, and placed the water on top of the bedside table. On August 16, 2012 at 8:21 a.m., C.N.A. #9 was observed to assist Resident #26 from the dining room to his room. Prior to having left the room, C.N.A. #9 was observed to clip the call light to the transfer pad. Soon after C.N.A. #9 left the room, the pad fell below the level of Resident #26's wheelchair, beyond his reach. On August 15, 2012 at 8:25 a.m.; RN #3 was asked about Resident #26's call light. RN #3 indicated Resident #26 was able to use the call light and has used it in the past. While explaining this, RN #3 repositioned the call light to within Resident #26's reach. Interview on August 15, 2012 at 8:55 a.m.; C.N.A. #1 indicated Resident #26 was at risk for falls. One of the things staff does for him as a fall prevention intervention is to keep a "reacher" by him at all times.			

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On August 15, 2012 at 10:18 a.m.; after a search around Resident #26's room, a reacher was observed to be hung on the wall by a screw. The reacher was positioned between his television and bathroom door. The reacher was in an area not easily accessible to Resident #26.

2. On 8/15/12 at 10:04 a.m., during an observation of Resident # 50's room, the bed was observed to be placed away from the wall, with a gap between the bed and the wall, and a safety mat on the floor between the bed and the wall. Near the head of the bed, a large black cord was plugged into the wall outlet. CNA # 3 indicated the cord was attached to a unit on the side rail that controlled the position of the electric bed. Resident # 50 was seated in her recliner.

On 8/16/12 at 08:11 a.m., CNA # 3 indicated the bed was pulled away from the wall for turning and repositioning because the resident required the assistance of two.

A care plan problem reviewed on 8/16/12 at 1:32 p.m. entitled, "Activities of Daily Living Self Care Deficit" with a goal date of 9/1/12, included the interventions: assistance

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	of two, turn and reposition, 1/2 side rails as an enabler. A care plan problem reviewed on 8/16/12 at 1:32 p.m., with a goal date of 8/24/12, indicated the resident was at risk for falls and injury, due to history of falls and potential for falls, related to history of cerebral vascular accident with right hemiparesis, hypertension, atrial fibrillation, depression, and anxiety. Functional problems included, decreased mobility related to the use of an antidepressant, Seroquel, and antihypertensives. Goals indicated the resident would have a reduced risk of fall related injury by utilizing fall precautions. The safety mat intervention had been discontinued. A quarterly Minimum Data Set assessment, dated 5/22/12, was reviewed on 8/16/12 at 1:32 p.m. The assessment indicated the resident's Brief Interview for Mental Status score was 15/15. The resident required assistance of two people for bed mobility and transfer, did not ambulate, and utilized a wheelchair. The assessment indicated the resident had impairment on one side of the body, which affected both the upper and lower extremity, and the resident had no history of falls since			

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	the prior assessment. On 8/16/12 at 9:35 a.m., the Assistant Director of Nursing (ADON) indicated the bed was pulled away from the wall so the CNA's would have room to reposition the resident. She indicated the bed had been placed on the exterior window wall as requested by the resident. She indicated she did not see any safety concerns with the gap between the bed and the wall. On 8/16/12 at 10:32 am., the ADON measured the gap between bed and wall. The gap measured: 11 2/16 inches at the head of the bed, 12 3/16 inches at the top of side rail, 14 3/16 inches at the end of the side rail, and 19 3/16 inches at the foot of the bed. On 8/16/12 at 1:07 p.m., CNA # 2 indicated the resident was able to help with repositioning by using her unaffected arm and the siderail. She indicated the safety mat was there because when the resident was located on another unit, she had fallen out of bed. She indicated the resident's mobility had declined since then and the resident was no longer able to get out of bed unassisted. She indicated the resident still had moments of confusion.			

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	155712	A. BUILDING 00 B. WING	08/21/2012

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	On 8/16/2012 at 1:23 p.m., RN # 2 indicated the resident was able to utilize the side rail with her left arm to roll herself to one side with some assistance. She indicated the resident does have some short term memory loss and intermittent confusion. She indicated the resident had fallen from bed over a year ago. On 8/16/12 at 1:40 p.m., the resident indicated the staff had never talked to her about the safety of the gap between the wall and the bed. 3.1-45(a)(1) 3.1-45(a)(2)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review, the facility to ensure drugs were given only with adequate monitoring, Resident #101, in that the facility failed to obtain and monitor labs results while administering coumadin therapy (drug used to thin the blood) and failed to ensure non-pharmacological interventions were utilized for 2 of 10 residents reviewed for unnecessary drugs. (Residents # 50)	F0329	F 0329 CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: All new admissions orders will be reviewed in Clinical Morning Meeting Mon-Fri. A list will be requested from our pharmacy every two weeks, of all pending labs. That list will be cross referenced to lab results and the lab log to ensure all labs were completed in a timely manner. The lab ordered for resident #101 was obtained on 8-16 with	09/20/2012

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	Findings include: 1. Resident #101's clinical record was reviewed on 8/16/12 at 7:58 A.M. Diagnoses included, but were not limited to: hyperlipidemia, diabetes mellitus II, and ischemic heart disease. The resident was admitted to the facility on 7/28/12, following a hospital stay due to having fallen and hitting his head at home. Medications ordered on admission, included Coumadin 7 mg daily, a drug which thins the blood to prevent blood clots. A lab result sent from the hospital was Protime 26.8 H (high), normal 9.7 to 12.3, and INR 2.57 H (high), normal range .95 to 1.11. A telephone physician order, dated 8/11/12, indicated PT/INR due on 8/11/12. During interview with the Unit Manager. RN # 1, on 8/16/12 at 8:30 A.M., she indicated the PT/INR due on 8/11/12, was "just missed." RN #1 indicated on 8/16/12 at 2 p.m. the labs had been sent and the resident had an appointment with his physician at 2:00 P.M. that same day.		physcian notified of results, there were no change in med orders, re-check pt/inr orders in one month. There was no negative outcome. Resident #50 was seen by Psychological Services on 1-17-12 for verbal expressions of distress, nervousness, appearing sad, losing track of time and missing family. Following incident with moving van, on 1-28-12 the niece attempted to talk with resident, the nurse documented that attempts at re-direction were unsuccessful, the facility contacted the residents physician who came in to visit with the resident. It was at this time an order was received to increase the Seroquel from 25mg to 50mg. Social Service documented on 1-31-12 that she had improved since medication adjusment. The campus will have monthly Behavior Monitoring/Psychotrophic Drug meetings with IDT which will include the DHS, ADHS, Social Service Director, Psych Services, Medical Director and Pharmacy Consultant. Gradual Dose Reductions as well as non-pharmacological interventions will be discussed for those residents in their assessment period that month who are currently on psychotropic meds. The report will be reviewed the following month in Quality Assurance Committee for further recommendations. IDENTIFICATION OF OTHER	

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	On 8/16/12 at 11:00 A.M. the DON (Director of Nursing) provided the lab results for Resident #101 dated 8/16/12. The results were prothrombin time 22.3 H(high) (normal range 9.7-12.3) and INR 2.12 H (high) (normal range .95 to 1.11). The 2010 Nursing Spectrum Drug Handbook indicated Coumadin, for Patient monitoring: "Monitor PT, INR."		RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN:All residents have the potential to be affected by this alleged defiecient practice. Will review the medical record of all residents receiving psychoactive medications and medications that require specialized monitoring and labs to ensure a careplan is in place for the use of the medication and non pharmacological interventions are attempted prior to use of medications that have potential for negative side effects.MEASURES PUT IN PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Educate Licensed Nursing staff on transcription of lab orders with inservice on 9-11-and 9-13. DHS or designee will re-educate the Interdisiplinary Careplan Team on the following: The campus guideline for completion and appropriateness of interdisiplinary careplans. The DHS or designee will re-educate the Licensed nurses or the following related to non-pharmacological interventions prior to use of psychoactive medications: 1). Administration of PRN Medications Guideline 2). Mental Health Wellness Treatment	

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			Planning. 3). Coumadin Monitoring/PT-INR with timely labs and proper notification. HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Will audit TARS/Lab sheet twice per week to ensure labs are signed off and completed. Per the campus guidelines, the nursing leadership team will review the 24 hour report, circumstance forms, telephone orders and change in condition forms in the daily clinical meeting 5 days a week, ongoing. This review is to ensure the careplans have been initiated/updated as necessary to provide adequate monitoring of psychotropic medication and coumadin use and related diagnosis. In addition, thru the daily clinical meeting, the monitoring of documented non-pharmacological interventions prior to psychotropic administration will be reviewed. The daily clinical meeting report will be completed to document the review of the above stated reports/forms.The following audits and/or observations will be conducted by the DHS or designee 2 times per week for 4 weeks, then monthly for 5 months to ensure compliance. 1). Review the medical record for residents receiving psychotropic medication to ensure a careplan is in place	

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	2. The record for Resident # 50 was reviewed on 8/16/12. Diagnoses included: anxiety disorder, depression, heart failure, hypertension, hyperlipidemia, aphasia, cerebral vascular accident, hemiparesis, muscle weakness, atrial flutter, joint stiffness. Active medications included antipsychotic and antidepressant. The medication administration, dated July, 2012, included, "...Seroquel, 50 milligrams, one tablet at bedtime, for vascular dementia with agitated and psychotic behaviors..." A care plan problem, dated through 12/15/12, titled, "Psychotropic Drug Use", noted the use of the		with appropriate diagnosis identified and provide adequate monitoring for its use. 2). review the use of PRN or new/changed orders for a psychotropic medication to ensure documentation is in place to support the attempts of non-pharmacological interventions prior to administration. 30. Review all residents on coumadin therapy for appropriate labs.The results of the audit observations will be reported to and reviewed by the Quality Assurance Committee for 6 months for further recommendations.	

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	anti-psychotic medication Seroquel with a dose change on 12/14/11 and 1/25/12 and included the diagnosis of vascular dementia with agitated psychotic behaviors. A goal indicated, "...Resident will receive minimal dosage of the prescribed psychotropic drug(s) to ensure maximum functional ability both mentally and physically..." An intervention indicated, "...Work with physician/pharmacy to provide lowest therapeutic dosage..." A quarterly Minimum Data Set assessment, dated 5/22/12, included a Brief Interview of Mental Status score of 15/15, which indicated cognitively intact, and no behavioral symptoms noted. A physician's progress note, dated 1/28/12, indicated, "...increased agitation since December. Seroquel was decreased in Dec. [December]...determined to go home...Pt [patient] has consented to stay a 'couple more days' until 24 hr [hour] a day home care can be obtained...Will go back to Seroquel 50..." A social services note, dated 1/31/12, indicated, "...This writer advised of Resident's increased confusion.			

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	Calling moving van see NN [nurses note] of 1/28/12...This writer spoke with resident and she has voiced no concerns @ [at] this time and is content to stay @ [at] facility..." A social services note, dated 6/28/12 (late entry for 6/25/12) indicated ,"...Clarification order recv'd [received] for Dx [diagnosis] on Seroquel per Psychiatrist Vascular Dementia c [with] agitated psychotic fx's [features]. C/P [care plan] updated..." During an interview on 8/17/12 at 2:15 p.m., the Social Services Director indicated after the incident of the resident attempting to call a moving van, no non-pharmacological interventions were attempted before the Seroquel dose was increased from 25 milligrams to 50 milligrams on January 28, 2012. A facility policy, presented by the executive director on 8/17/12, titled, "Clinically At Risk (CAR) Program Guidelines for Behavior Discussion and Interventions" included, "...The CAR team will meet weekly to discuss those residents that meet the behavior criteria of the Clinically at Risk program....2. Discussion should include:...what behaviors have been exhibited, what interventions have			

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	been tried, were they effective..." 3.1-48(a)(3) 3.1-48(a)(4)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and record review, the facility failed to ensure sanitary measures were followed during 2 of 2 meal observations. This had the potential to affect 90 of 90 residents who reside in the building. Findings include: During observation of the noon meal, on 8/13/12 at 12:15 P.M., LPN #1 was observed to deliver food trays. She placed the serving tray under her arm with the inside of the tray where the food sits observed to touch her uniform. She was observed to then have more food placed on the tray and delivered the food to a table. On 08/13/12 at 11:55 a.m. the noon meal was observed being served. Cook #1 was observed to wear gloves and handle tongs to pick up pieces of steak and to place the steak on resident plates. Cook #1 was observed to wear the same gloves while she removed baked potatoes	F0371	F 0371 CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: Upon notification of this alleged deficient practice, all dining services staff were inserviced regarding guidelines for handwashing. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN: All residents who eat within the dining area have the potential to be affected by this same alleged deficient practice, and will be monitored for appropriate infection control practices related to their meal preparation delivery and service. MEASURES PUT INTO PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR: Dietary Manager, or designee will review campus guidelines for handwashing, and inservice dietary employees on proper handwashing techniques.HOW	09/20/2012

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	from foil and squeezed the potatoes before placing on resident plates. Cook #1 while wearing the same gloves was observed to pick up individual butter packets and place on the residents plates and with the same gloved hands placed rolls on the residents' plates. During observation of the noon meal service, Head Cook # 1, was observed to remove her gloves and start flipping through the menu orders(papers completed by residents or staff indicating their choice for the meal), part of the way through the stack she licked her finger, then was observed to glove back up, and dipped more foods, without washing her hands. A policy titled "Guidelines for Brainwashing" was provided by the facility on 08/17/12 at 2:30 p.m. The policy was dated 10/2004. The policy indicated, "Purpose - Handwashing is the single most important factor in preventing transmission of infections. Inadequate handwashing has been responsible for many outbreaks of infectious disease in LTCF [Long Term Care Facilities]. Implementation of PROPER handwashing practices has interrupted outbreaks in many		THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR: Dietary Manager or designee will observe hand washing procedures within the kitchen and dining areas three times per week for two months, then one time weekly for four months to ensure compliance. The audits will then be conducted randomly as needed thereafter. The audits will be reported to the Quality Assurance Committee monthly for further recommendations. HOW WILL SYSTEMIC MEASURES ENSURE NURSING DOESN'T REPEAT NON-COMPLIANCE? HOW LONG WILL QA MONITOR MEASURES? WHAT CRITERIA WILL DETERMINE MONITORING CAN BE DISCONTINUED?ADDENDUM: Inservice given to all staff on 9-11-12 and 9-13-12 with a follow up inservice to be given on 9-25-12 and 9-27-12, to ensure all staff follow sanitary procedures with serving food. When audits are conducted, if issues are noted at that time, the Dietary Manager/designee or Nursing designee will re-educate that person immediately. QA Committee will monitor audits for 6 months and then discontinue, if there are no further issues of non compliance with infection control.	

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	settings...Procedure: 1. All health care workers shall wash their hands frequently and appropriately....Health Care Workers shall wash hands at times such as:...before/after preparing/serving meals, drinks...On reporting to work; before/after eating; after...handling hair, etc...." A form titled "Food Safety: Personal Hygiene and Hand Washing...Gloves are to protect the food, not to keep the hands of the employee clean. Change gloves between each activity - do not wash or reuse gloves...." 3.1-21(i)(3) 5-5.1(f)			

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to	F0441	F 0441 CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE	09/20/2012

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	ensure signs were posted to alert visitors and/or staff to contact the nurse before entering a room for 1 of 3 residents reviewed requiring a sign, Resident #22, Resident #25, failed to ensure a laundry aid delivered clean laundry in a sanitary manner for 1 of 1 laundry aide observed to pass clean clothing, potentially affecting all residents on the unit whose laundry was done by the facility, and failed to ensure staff members washed their hands for 1 of 6 observations of handwashing as indicated by the facility's handwashing policy [Resident #56]. Findings include: 1. During interview with Resident #22's roommate, Resident #25, on 8/13/12 at 10:30 A.M. she indicated Resident #22 had some type of infection in her intestines. Resident #25 indicated she was using the bathroom across the hall as only Resident #22 could use the one in their room, shared by them normally. The shared bathroom was observed on 8/13/12 at 10:30 a.m. to contain red bags and an isolation trash container. No signs were observed on the bathroom door or the room doorway. The room and bathroom		RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: The precaution sign was posted immediately on 8-14-12 when DHS was made aware by surveyor. Laundry/Housekeeping staff were educated on 9-11 regarding guidelines for distribution of clothing and linens and infection control procedures. Laundry and Housekeeping staff will be required to complete Emerge training on infection control (Trilogy online inservice programming) by 9-20-12. CNA #2 mentioned in survey was educated on 8-16-12 regarding guidelines for handwashing.IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN: All residents have the potential to be affected by the alleged deficient practice if they have their laundry done by the campus, receive peri care, or are exposed to an infection. Infection control practices will be monitored daily during administrative rounds. MEASURES PUT IN PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Spot check 3 residents for peri care weekly for 60 days then monthly for 4 months.	

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	were observed on 8/14/12 at 10:00 A.M. to have no sign on the door of the room or bathroom. During record review for Resident #25 on 8/14/12 at 11:00 A.M., the resident was currently being treated for C-difficile (an infection of the intestines). The physician had ordered a test for C-diff on 8/1/12 with treatment started on 8/6/12. The policy and procedure for Clostridium Difficile was obtained on 8/14/12 at 11:00 A.M. from RN #1. The policy indicated "Precaution Sign: " Post a sign at the resident's door to advise the visitors to consult with the Charge Nurse before entering the room." During interview with the Director of Nursing on 8/14/12 at 11:30 A.M. she verified there was no sign posted and indicated there should have been and would get one immediately. 2. During observation of Laundry staff #1, providing clean personal clothing to residents, on 8/14/12 at 12:00 P.M. she was observed to bring a rack of clean clothes covered down the hall, removed a residents clothing from the rack, and pack them to the residents room, touching her uniform with the residents clean clothing. She		Laundry and Housekeeping Supervisor will observe 3 staff members 3 times per week for 2 months, then 3 staff members monthly for 4 months. All documentation will be given to Quality Assurance Committee monthly for 6 months for further recommendations. HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:DHS or designee will audit two residents per week for applicable infection precaution signs. The audits will be turned into the Quality Assurance Committee for further recommentations for 6 months. WHAT SYSTEMS MEASURES WILL BE TAKEN TO ENSURE ALL STAFF, INCLUDING ALL NURSING, ARE EDUCATED ON INFECTION CONTROL? ADDENDUM:Mandatory inservice to educate all staff on 9-25-12 & 9-27-12 on infection control, including proper procedure in removing gloves, washing hands, peri care, when/where to place infection signs. Then monthly inservices will be held with staff for 6 months on infection control. DHS or designee will audit three residents and nursing staff per week for 60 days, then three residents and nursing staff monthly for 4 months. During these audits if any problems are noted, 1:1 inservicing will be done with the individual at that time. All	

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	was then observed to go down the hallway, and then removed two more residents clean clothing again touching her uniform as she delivered the clean clothing. She was observed to enter 5 rooms with the clean clothing touching her uniform each time as she took them down and into the residents room. During interview with the laundry staff member on 8/14/12 at 12:09 p.m., she indicated she had been working part time to fill in for laundry for the past few months. She further indicated she had not received any training in how to deliver the clothing or the need to not touch her uniform with the clean clothing. The ED (executive Director) provided the policy and procedure for "Guidelines for Handling Linen" on 8/16/12 at 12:30 P.M. The policy indicated Clean Linen-"linens should be carried away from the body to prevent contamination from clothing." 3. On August 15, 2012 at 10:57 a.m.; C.N.A. #2 was observed to provide incontinence care to Resident # 56. Resident # 56 was observed to have been incontinent of bowel and bladder. C.N.A. #2 removed the soiled brief, provided incontinence care of the perineal area, and remove the gloves worn during peri-care. C.N.A. #2 was observed to not wash		audits will be brought to QA committee for further recommendations. If, after 6 months, no further issues have been noted with infection control, the QA committee will discontinue monitoring.	

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	her hands after having removed the gloves. C.N.A. #2, without having washed her hands, obtained a clean brief and dressed Resident # 56 . On August 17, 2012 at 9:05 a.m. the Director of Nursing provided a copy of the facility's Guidelines For Handwashing dated October 2004. Review of the policy indicated, "Purpose: Handwashing is the single most important factor in preventing transmission of infections. Inadequate handwashing has been responsible for many outbreaks of infectious disease in LTCF [long term care facilities]. Procedure: All health care workers shall wash their hands frequently and appropriately. ... 3. Health Care Workers shall wash hands at times such as: d. After removing gloves, .. 8. Wash well for 15-20 seconds ..." 3.1-18(j) 3.1-18(l) 3.1-19(g)			

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F0456 SS=C	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview, the facility failed to maintain 1 of 1 laboratory refrigerator in a safe operating condition, which had the potential to affect all residents' materials, fluids, and tissues obtained and stored for laboratory analysis. Findings include: During the environmental tour on August 16, 2012 at 2:20 p.m.; with the Maintenance and Housekeeping Directors present; the laboratory refrigerator [a controlled environment in which materials, fluids, and/or tissues obtained from residents are stored until laboratory services are able collect for analysis] was observed. The refrigerator lacked a thermometer, in which to measure the interior temperature. No documentation was present, which indicated the interior temperature was being monitored. The Housekeeping Director obtained a refrigerator thermometer, positioned	F0456	F 0456 CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: A thermometer was placed in the refrigerator on August 16th and after cooling to appropriate temperature levels, it has been within acceptable range- 36-46 degrees F -as evidenced by the log completed by staff each night. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN:All residents who have lab specimens stored in the refrigerator have the potential to be affected by alleged deficient practice. Nightly monitoring of temperatures has been initiated effective 8-16-12 to maintain safe storage levels. MEASURES PUT IN PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:The campus initiated a temperature log to be maintained nightly for monitoring appropriate temperatures for specimen storage. Environmental Services will be notified of temperatures	09/20/2012

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	the thermometer inside the refrigerator, and closed the door. After approximately fifteen minutes the thermometer indicated the interior temperature measured 50 degrees Fahrenheit. Thirty minutes later, with the Housekeeping Director present, the thermometer which had been positioned inside the laboratory refrigerator was observed. The thermometer indicated the interior temperature was 56 degrees Fahrenheit. The Director of Nursing was interviewed on August 17, 2012 at 11:00 a.m. The Director of Nursing indicated the facility did not have a system in place to monitor the interior temperature of the laboratory refrigerator. The Director of Nursing had contacted the facility's lab, and the lab indicated the laboratory refrigerator temperature should be maintained between 36 and 46 degrees Fahrenheit. 3.1-19(bb)		outside acceptable parameters to determine if there is a problem with the thermometer. If that is not the case, then the hospital will be contacted, as that particular refrigerator belongs to the hospital lab.HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:The logs will be reviewed during daily rounds 3 times a week for 60 days then monthly for 6 months by the DHS or designee and forwarded monthly to the Quality Assurance Committee for further recommendations. WHAT SYSTEMS TO ENSURE DEFICIENT PRACTICE DOES NOT RECUR? I.E.; INSERVICING?ADDENDUM: Inservice nursing staff on 9-25-12 and 9-27-12 to ensure they are recording temperatures on the lab refrigerator nightly, and that they are within proper range (36 - 46 degrees). Notify Nursing Administration if temperatures are not within range so that further steps can be taken to correct the problem. i.e.; change thermometer, have maintenance check the refrigerator for a problem. If there are specimens in the refrigerator and the temperature is not at a safe range, then staff may be instructed to place specimens in a cooler with ice and transport to hospital lab as soon as possible.	

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R0052	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure care was provided in a timely manner for 1 of 3 residents reviewed for staff treatment of residents. (Resident #68) Findings Include: On 08/20/12 at 12:50 p.m. CNA #13 and LPN #8 were observed to toilet Resident #68. CNA #13 and LPN #8 talked softly to the resident and asked her about her farm and her garden. The resident was cooperative during the care. CNA #13 was observed to remove a wet brief and cleanse Resident #68's bottom and peri-area with soap and water, and rinsed and dried the resident's skin. The resident was observed to have reddened buttocks and posterior legs. CNA #13 was observed to apply Calyzyme lotion (barrier cream) CNA #13 indicated at that time that the barrier cream was used every time the resident was toileted or incontinent.	R0052	R 0052 CORRECTIVE ACTIONS ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: The resident was immediately toileted and changed when brought to the attention of the oncoming shift. No adverse affect to resident noted. The incident was investigated immediately by the ED and DHS. LPN #1 and CNA #9 were suspended pending investigation. And upon completion of investigation, both employees were terminated. the incident was reported to ISDH on 8-16-12. Inservices for staff will be held on 9-11-12 and 9-13-12 on how to prevent, identify, protect and report, all types of abuse (verbal, physical, sexual, mental, emotional, involuntary seclusion, misappropriation of property and neglect.) and how to approach residents with behaviors. IDENTIFICATION OF OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ALLEGED DEFICIENT PRACTICE AND CORRECTIVE ACTIONS TAKEN: has the	09/20/2012

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	During review of reportable occurrences on 08/20/12 at 10:30 a.m. the following was noted.: Documentation provided by the ED [Executive Director] on 08/20/12 at 11:00 a.m. indicated, "....Incident Date: 8-15-12 Incident Time: 2:00 PM. Resident Name: [name of Resident #68]....Diagnosis: Profound Dementia Alzheimers...Staff involved....[LPN #1]...[CNA #9]...Brief Description of incident: The second shift nurse, (LPN #7), reported to the Director of Health Services on 8-15-12 after her shift started on [Name of Unit Resident #68 resided on], that the day shift staff, [LPN #1] and [CNA #9] stated that [name of Resident #68] had not been toileted during their shift because she was resistive to care. [Name of LPN #7] stated to the other nurse at that time that [name of Resident #68] had to be checked, so [name of LPN #1 and name of LPN #7] took [name of Resident #68] to her room to be toileted and changed....Immediate Action Taken: Resident toileted and changed immediately Suspension of both employees; resident skin assessment completed with no reddened/open areas noted on peri area and buttocks....Preventive		potential to affect all residents with this alleged deficient practice.The facility will continue to implement all aspects of the abuse policy and procdures including screening, training, prevention, identification, protection, investigation, reporting. MEASURES PUT INTO PLACE AND SYSTEMIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:The facility will continue to follow our written policies and procedures for abuse prevention, investigation and reporting. HOW THE CORRECTIVE MEASURES WILL BE MONITORED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT RECUR:Quality Assurance Committee will review all incident/accident reports and reportable incidents in monthly meeting for further recommedations on ongoing basis.	

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	measures taken: Barrier cream applied with each check and change and prn. Residents' skin assessed x [times] 48 hours for redness. Inservices will be held for staff to re-educate them on how to approach and care for residents with behaviors." During review of Resident #68's clinical record on 08/20/12 at 8:30 a.m., nurse's notes indicated Resident #68 was combative with care at times, and other times she was cooperative with care. Interview of LPN #9 on 08/20/12 at 3:55 p.m. indicated Resident #68 was at times combative with care and if you asked the resident if she needed to go to the bathroom she would always say "no." The ADON indicated if you talked softly to the resident and told her you were going to show her something she would usually follow right along. LPN #9 indicated Resident #68 could be combative one minute and "sweet as pie" the next minute and she had never known the resident to be combative the entire shift. Interview of the ADON [Assistant Director of Nursing] on 08/20/12 at 4:05 p.m. indicated the problem with			

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	the incident of the resident not being toileted or checked the entire shift was that LPN #1 and CNA #9 neither one asked for help. The ADON indicated LPN #1 and CNA #9 didn't call the Unit Manager and the Unit Manager (Unit Manager #1) could usually always calm the resident down. The ADON indicated staff are to never leave a resident unattended the entire shift and should always call someone else over to attempt care. Interview of The Executive Director on 08/20/12 at 4:20 p.m. indicated staff know they are always to re-approach a resident or call for assistance and CNA #9 and LPN #1 neither called for help and the resident was not changed for the entire shift. A typed statement from LPN #7 (the nurse who came on the second shift and reported the resident being left unattended the entire day shift) was provided by the ED on 08/20/12 at 4:30 p.m. The statement was dated 08/15/12 and indicated, "....During report from day shift, [names of LPN #1 and CNA #9] [Resident #68] had not been toileted their whole 8 hour shift (6AM-2PM). [name of CNA #9] said she wasn't doing it by herself and pulling on her and that she [Resident #68] was resistive. [Name of LPN #1]			

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	said that she [name of Resident #68] was not there the whole time, that she [name of Resident #68] was at therapy. [Name of LPN #7] told them that 'We have to change her.' [Name of LPN #7] said that at that point [name of LPN #1] told her that she would help, and pushed her paper work away and came to help with [name of Resident #68]. The resident had dried BM on her and was saturated with urine. When they sat her on the toilet she also urinated." A typed statement from QMA #20 was provided by the ED on 08/20/12 at 4:30 p.m. The statement was dated 08/15/12 and indicated, "When I (QMA #20) arrived on [name of unit Resident #68 resided on] today at 2PM, [name of CNA #9] gave me report. She stated that [name of [Resident #68] had not been toileted. [name of LPN#7] asked her if she had not been toileted all day and [name of CNA #9] said NO, she said she didn't have to go and [name of LPN #1] and I aren't going to break our backs to try to get her on the toilet when she's fighting. [name of CNA #9] said she would help us take her if we wanted to help toilet her. [Name of LPN #7] said yes, lets do that. We took [name of Resident #68] to the bathroom, and she stood up and let us change			

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	her...." A policy titled "Abuse and Neglect Procedural Guideline" was provided by the Executive Director on 08/15/12 at 9:55 a.m. This policy was dated, November, 2010. This policy indicated, "...Definitions: a. ABUSE means the willful infliction of injury, unreasonable confinement , intimidation, or punishment resulting in physical harm, pain or mental anguish (known and/or alleged.) This includes deprivation by an individual, including a caregiver, of goods and services that are necessary to attain or maintain physical, mental, or psychosocial well-being...."			